State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

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January 15, 2004

TO: INFECTION CONTROL PRACTITIONERS
HOSPITAL ADMINISTRATORS
EMERGENCY DEPARTMENTS

SUBJECT: ENHANCED SURVEILLANCE FOR SARS AND AVIAN INFLUENZA

Given the recent Severe Acute Respiratory Syndrome (SARS) situation in Guangdong Province, China and the avian influenza situations in Vietnam, Japan, and South Korea, recommendations for enhanced surveillance are described below. The Centers for Disease Control and Prevention (CDC) will also be sending out a Health Alert on these issues very soon.

**SARS**:
On January 5, 2004, the Chinese Ministry of Health and the World Health Organization (WHO) announced laboratory confirmation of SARS in a 32-year-old male television producer in Guangdong Province, China. This patient had onset of illness on December 16, 2003, was hospitalized, and had since recovered. The source of his infection has not been identified. On January 8th, suspect SARS was reported in a 20-year-old woman who works in a restaurant also in Guangdong, China. This patient had onset of fever on December 26, 2003, and was also hospitalized, but has not yet been laboratory-confirmed. And on January 12, we learned of another suspect SARS case in a 35-year-old male shopkeeper in Guangdong who had onset of fever on December 31 and who is now also hospitalized and awaits SARS laboratory test results. Contacts of these patients have been followed and, thus far, no illness has been reported among them. There is no known epidemiological link between these patients. WHO and CDC have not issued any new travel alerts or advisories at this time.

Based on current information and on further discussion with CDC and the Council of State and Territorial Epidemiologists (CSTE), we agreed to **enhance** surveillance for SARS. We are now recommending that physicians maintain a greater index of suspicion of SARS in patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome (ARDS) AND who have (in the 10 days before onset of illness) a history of travel to Guangdong Province, China or close contact with someone ill who had traveled there. Accordingly, for any patient who meets these criteria, we recommend the following actions:

1615 Capitol Avenue, Room 73.741, MS 3400, P.O. Box 997413, Sacramento, CA 95899-7413
Phone: (916) 552-8641 Fax: (916) 552-8640
Internet Address: www.dhs.ca.gov

1. Immediately isolate the patient using precautions appropriate for SARS (i.e., contact and airborne precautions). If no other pathogen is identified to explain the illness, isolation should be continued until 10 days after fever resolution and improvement of cough.

2. Immediately report the patient to the Local Health Department (LHD). The LHD should then report the patient to the Infectious Diseases Branch using the SARS Case Report Form. The form should be faxed to (510) 540-2570.

3. Consider testing the patient immediately for evidence of SARS-CoV along with other viral and bacterial pathogens. Laboratory testing for SARS-CoV should be done immediately rather than waiting the usually recommended 72 hours after admission. SARS testing is available at a limited number of local public health laboratories and at the California Viral and Rickettsial Diseases Laboratory (VRDL). Please contact your local health department to coordinate testing.

4. Evaluate close contacts of the patient, in particular household members and persons who provided care to symptomatic patients, daily for fever (T > 100.4 F or > 38 C) or respiratory symptoms (cough, shortness of breath, or difficulty breathing) for 10 days after last exposure to the patient. These contacts may continue with their daily activities and work routines as long as they don't have any fever or respiratory symptoms. Contacts who develop fever or respiratory symptoms should be asked to stop going to work or school and should be medically evaluated.

As described in our November 18, 2003, SARS Surveillance and Response Planning Guide for California Health Care Facilities (at http://www.dhs.ca.gov/ps/dcdc/disb/sars.htm), we continue to recommend that health care providers and public health officials consider SARS in the differential diagnosis of patients who have required hospitalization for radiographically confirmed pneumonia or ARDS and had no identifiable etiology after 72 hours of hospitalization AND who had one of the following risk factors in the 10 days before the onset of illness:

- Travel to mainland China (outside of Guangdong Province), Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas, OR

- Employment in an occupation associated with a risk for SARS-CoV exposure (e.g., healthcare worker with direct patient contact), OR

- Part of a cluster of cases of atypical pneumonia without an alternative diagnosis (infection control practitioners and other health care professionals should be alert to pneumonia clusters among health care workers in the same facility).

These recommendations could change depending on whether additional cases are laboratory-confirmed. If you have questions about these latest SARS surveillance recommendations, please call (510) 540-2566.

**AVIAN INFLUENZA:**

Besides SARS, there have been reports of avian influenza (primarily A H5N1) affecting thousands of chickens in Japan, South Korea, and Vietnam since October 2003, possibly causing 14 hospitalized human cases, including 12 deaths (11 children and 1 parent) in Vietnam. H5N1 has been confirmed in 3 of the cases thus far (WHO website: http://www.who.int/csr/don/2004_01_14/en/, http://www.who.int/csr/don/2004_01_13/en/). While additional investigations are ongoing, we recommend that any patient hospitalized for influenza or unexplained severe respiratory illness, ARDS or pneumonia be asked about travel to Japan, South Korea, and Vietnam in the 10 days before illness onset. If there is a history of travel to these countries in the 10 days before onset of symptoms, then appropriate specimens should be collected for testing including **viral culture** of nasopharyngeal and throat swabs. All influenza viruses should be typed and subtyped, and any viruses that cannot be subtyped should be submitted to the local public health laboratory (which can then forward to VRDL) for further characterization. Please see our website for more information (http://www.dhs.ca.gov/ps/dcdc/VRDL/html/FLU/Flu-h5n1.htm) about surveillance for influenza A H5N1 and the WHO website for updates on H5N1 activity (http://www.who.int/health_topics/influenza/en/). Additional surveillance activities may be recommended as more information becomes known. If you have questions about laboratory testing for avian influenza, please call Erin Isaacson of VRDL at (510) 307-8607.

Sincerely,

***Original signed by***

Diane L. Ford, Chief
Field Support Branch
Licensing and Certification Program